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Jo Killingley explores the teaching and learning features of a vaginal examination clinical skill for pre-registration student midwives

Introducing educational theory: vaginal examination

SUMMARY: A vaginal examination (VE) is one of many core skills used in midwifery practice. Despite the controversy of whether it is necessary in all situations, in this article I take the standpoint that it is useful in providing a full clinical picture, especially at times when closer monitoring is recommended. Additionally, if the core skill is misinterpreted, the findings of the VE can distort the true clinical picture. To support the student, subjective assessment and individual learning pathways must be addressed to avoid unnecessary intervention and psychological impairment to the woman. This article explores some of the difficulties encountered with teaching and learning VE in clinical practice and offers concepts from educational theory to assist in clarifying the difficulties and offering new ways of thinking for both students and midwives.

Keywords Vaginal examination, student midwife, assessment, education tool

Author Jo Killingley, midwifery lecturer at Middlesex University

Student midwives gain the majority of their knowledge and skills in clinical practice by means of role modelling

Diagnosing labour is multifaceted. Debate around the vaginal examination (VE) is a true indicator of progress (Walsh 2008) and the frequency with which it is offered (Dixon and Foureur 2010) is topical. However this article is not about exploring these factors; it is an enquiry to support the student by introducing an educational theory about how they learn and how they can be responsible for developing their skills in practice, as VEs remain a routine intervention in the assessment of labour (Downe et al 2013).

Teaching and learning

Student midwives gain the majority of their knowledge and skills in clinical practice by means of role modelling (Gordon 2003) and

therefore it remains a vital component that theoretical input supports the student and their mentor in the clinical environment in order for them to be fit for practice with the essential core skills (Nursing and Midwifery Council (NMC) 2004).

Exploring diversity, misinterpretations and misunderstandings of the VE and how this can lead to midwives interpreting their findings is key in diagnosing, planning and implementing the care of women. With any exploration, it is necessary to explore the pedagogy to identify any supportive themes emerging as these can highlight the philosophical underpinning of the subject (Diekelmann and Diekelmann 2009) and could be developed to provide a clearer structure for teaching in the classroom.

There can be no doubt that VE is an

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Figure 1 Principles of vaginal examination assessment

Observations	Rationale	Action
Vital signs	Ensure vital signs remain within normal limits	Refer to the appropriate professional, if outside these limits
Bladder care	Allow descent of the presenting part without damage to the bladder	Ensure privacy and dignity are maintained. Offer positions to encourage micturition. If a bladder is palpated, consider (intermittent) catheterisation
Abdominal palpation	Confirm size, presentation, position and lie	Refer to the appropriate professional if breech birth is suspected, or growth questioned
Contractions	Assess strength, frequency and length	Confirm established labour. Exclude hyperstimulation
Fetal heart auscultation	Identify any abnormal features and ensure normality	Refer to NICE guidance in the first stage of labour and request medical support in the second
Vaginal examination	Assess cervix for position, presentation consistency, dilation, and application to the presenting part, any fontanelles or suture lines; the position in relation to the maternal pelvis and the presence of abnormal features (caput/moulding and umbilical cord)	Any concerns or abnormal findings, seek appropriate support. Malpositions should be managed by offering a change of position to encourage rotation of the fetal head
Diet and fluid	Remain hydrated	Light diet and continue with fluids to avoid dehydration
Emotional state	Ensure the woman is showing normal behaviour	Assess for signs of acopia. Support as required

essential element in identifying labour (*Figure 1* presents the principles of assessment), not to mention determining the degree of it and potential problems associated with it. There is also no doubt that many students and qualified midwives lack a comprehensive understanding of the VE skill. This latter statement is borne out by testimonials (*Figure 2*) from midwives who have, during their post qualification experience, discovered their shortcomings in conducting the VE and what it could discover if performed correctly. This is not a reflection on midwives and student

midwives, but on the learning process, both in theory and practice during courses.

Student midwives are to engage with their assessors, listen to their experience and question how they should process the 'difficult' skills in the clinical area in order to understand them.

The threshold concept

Strangely, it was not a medical concept that identified problems associated with learning a subject with 'difficult or troublesome areas' and VE has its fair share of difficult and troublesome areas. It was, in fact, Meyer and

Land (2006) who named this theory (developed from economy education), 'the threshold concept'. They recognised that when the student failed to grasp an aspect of what is being taught, described as 'troublesome' knowledge, it resulted in partial understanding, and therefore the student lacked the essence or philosophy of the task. Meyer and Land identified that a student could pass the necessary assessments to complete the course without thinking like an economist. This theoretical framework supports the philosophy of the VE, since obtaining the skills and understanding is paramount to the accuracy of the task; interrelatedness and key factors in the process of birth, such as identifying features of the fetal skull, anatomy of the pelvis and the six ways to identify progress (Simkin and Ancheta 2000) are central to gaining a deeper knowledge. Some may argue that the VE skill is not a true threshold concept; to those, it could be pointed out that,

Figure 2 Colleagues' testimonials

“ I remember a vaginal examination where I was certain that the woman was fully dilated and told this to the midwife in whispers. Had I looked at the woman and at the whole picture and seen that the woman was quite relaxed and actually not in pain at all I may have delved a little deeper. I had not considered the posterior position of the cervix and was feeling the smooth tissue anteriorly which I thought was a head. ”

“ I didn't really have a clue throughout my training, no examination was the same. I only felt the cervix for the first time when I was inserting a prostin pessary which was fairly late in the third year. It all came together when I asked another midwife whom I trusted, to check my VE's (regularly) post qualification. It was then that I became confident. ”

Figure 3 Reflection points

How do they feel about VEs?

What are your experiences?

Does this affect your practice?

What are the challenges in your clinical area?

What have you observed in practice?

How can you use reflection to improve your practice?

if the theory is examined, there are associations which support this method of teaching the subject, and therefore it is of considerable value to the student.

It is believed that one of the reasons for the lack of understanding of VE and its findings, and moreover what makes it difficult and troublesome, is the fact that it is an invasive and uncomfortable procedure which the expectant mother would prefer not to undergo and consequently, the midwife or student midwife finds himself/herself unwilling to prolong the discomfort to the expectant mother, thereby not exploring and discovering all aspects of labour.

Liminal space

The main theme within the teaching, considered beneficial to the student, is to introduce the notion of 'liminal space'. This is the period of time where the student has the knowledge, but is waiting for the understanding to fall into place: known to some as the 'eureka' moment. The value in introducing this concept was to embrace the normal process of learning without the uncomfortable stigma of not attaining the skill. For some students, even the smallest anxiety can affect their confidence, and that creates a barrier to learning.

Learners differ

From the literature it is clear that students learn in many ways and at different speeds. This can have adverse outcomes for the student if the pace moves faster than they do. Typically, experience in clinical practice can vary between students which may not be conducive to their individual pace and may create unnecessary stress and pressure, hindering their ability to proceed or progress. Knowledge is accumulated as we progress through life and work experiences; as knowledge is held in structures, known as schemata, the student is able to build upon new knowledge, giving a new stance to the same situation. Recognition of one's schemata is a key aspect in understanding how we learn and store knowledge (Gilkison 2013). Therefore identifying learning styles and educational theories can be useful.

In addition to visual and practical aids, the session was designed to include a series of prepared testimonials from experienced colleagues. The testimonials described how they felt and when they became competent or reached a true understanding of the VE skill (See Figure 2). With the use of these testimonials and reflection points (Figure 3) in the classroom, the students appeared comforted by the experience of those more qualified. Moreover, they considered the topic less troublesome and felt more comfortable in their liminal space, which can be utilised in most aspects of student learning.

Pressure

Historically, students appear to feel pressure to obtain the relevant births and skills in the clinical area. This can divert their observations and attention away from important components in the acquisition of values and beliefs of the profession. Imparting an educational theory to student midwives, prior

to practising the VE, could have an effect on the pressure students feel in the clinical environment to obtain the skill. Ultimately, this would allow students to focus on the value of observation and being with-woman, and watch out for that purple line (Wickham 2007; Shepherd et al 2010)! [tpm](#)

Jo Killingley is a midwifery lecturer at Middlesex University

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